



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

TWELVE OAKS MEDICAL CENTER  
C/O HOLLOWAY & GUMBERT  
3701 KIRBY DRIVE SUITE 1288  
HOUSTON TX 77098-3926

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-06-7758-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "IC failed to pay per DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline. Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed \$40,000.00 stop-loss threshold. IC further failed to audit according to DWC Rule 134.401(c)(6)(A)(v)."

**Amount in Dispute:** \$37,261.48

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "...the admission did not have services that were unusually extensive or unusually costly and total audited charges do not exceed the minimum threshold of \$40,000. Payment under the stop-loss exception has not been justified by the hospital in this case, and Texas Mutual's payment under the per diem plus carve-outs method is appropriate."

**Response Submitted by:** Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2005 Through September 2, 2005	Inpatient Services	\$37,261.48	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on August 21, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 25, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated November 18, 2005

- CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- CAC-150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- CAC-97-Payment is included in the allowance for another service/procedure.
- 426-Reimbursed to fair and reasonable.
- 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
- 730-Denied as included in per diem rate.
- Billed charges do not meet the stop-loss method standard of the 08/01/97 Acute Care Inpatient Hospital Fee Guideline. The charges do not indicate an unusually costly or unusually extensive hospital stay. The intent of stop-loss payment is to compensate hospitals for i.

Explanation of Benefits dated January 4, 2006

- CAC- W1-Workers Compensation state fee schedule adjustment.
- CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-97-Payment is included in the allowance for another service/procedure.
- 426-Reimbursed to fair and reasonable.
- 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
- 730-Denied as included in per diem rate.
- 891-The insurance company is reducing or denying payment after reconsideration.
- Billed charges do not meet the stop-loss method standard of the 08/01/97 Acute Care Inpatient Hospital Fee Guideline. The charges do not indicate an unusually costly or unusually extensive hospital stay. The intent of stop-loss payment is to compensate hospitals for inpatient s.

## **Findings**

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 805.4. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that "IC failed to pay per DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline. Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed \$40,000.00 stop-loss

threshold. IC further failed to audit according to DWC Rule 134.401(c)(6)(A)(v).” Division rule at 28 TAC §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that “The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.” As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.

3. 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include “a copy of all medical bill(s) as originally submitted to the carrier for reconsideration...” Review of the documentation submitted by the requestor finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
  - The requestor’s rationale for increased reimbursement from the *Table of Disputed Services* asserts that “IC failed to pay per DWC Rule 134.401 Acute Care Inpatient Hospital Fee Guideline. Per DWC Rule 134.401(c)(6), claim pays @ 75% of total charges as charges exceed \$40,000.00 stop-loss threshold. IC further failed to audit according to DWC Rule 134.401(c)(6)(A)(v).”
  - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per 28 Texas Administrative Code §134.401(c)(6).
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
  - The Division has previously found that a reimbursement methodology based upon payment of a hospital’s billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
  - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
  - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

## **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

**Authorized Signature**

_____	_____	1/20/2012
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	1/20/2012
Signature	Medical Fee Dispute Resolution Manager	Date

***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**